Incentivising preventive services in primary care: perspectives on Local Enhanced Services

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Abstract

Background

General practitioners (GPs) in the UK play a key role in prevention but provision of preventive services is variable. The 2004 General Medical Services contract allows Primary Care Trusts (PCTs) to address health needs through locally agreed payments for Local Enhanced Services (LESs). This study identifies how this contractual flexibility is used for preventive services and explores its perceived effectiveness.

Methods

Semi-structured interviews were carried out (2008-09) in 10 purposively selected case study sites in England. Details of LESs for these sites were collected (2009) through Freedom of Information (FOI) requests or local contacts. A national on-line survey of PCTs (2009) provided a national context for case study findings.

Results

LESs were considered to be effective in incentivising preventive activity. However, specifications and performance management were often weak, awareness of how to optimise incentives was low and, as optional services, LESs were perceived to be at risk in a financial downturn.

Conclusions

Using LESs for preventive services highlights gaps in 'core' primary care responsibilities and in the national pay-for-performance framework. Current incentive arrangements are complex, could increase inequity and provide only a partial, short-term solution to developing a proactive approach to prevention in primary care.

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Background

The use of incentives to improve the quality and outcomes of care is widespread. While ideas of agency, motivation and incentives are often considered central to improving performance, it has been argued[1] that there is a 'lack of coherent established theory with predictive validity' on the use of incentives in health care. A systematic review of 'pay-for-performance (P4P) schemes',[2] including those for preventive services, found mixed evidence that schemes improved quality of care over the longer term. However, recent evidence from the UK[3] demonstrated that incentives can act as powerful levers to change primary care professionals' behaviour, reducing variation in the quality of care and contributing to meeting targets. This study supported previous findings[4] that incentive programmes need to take account of unintended consequences and recognise 'knightly and knavish'[5] motivations. Theoretical analyses have set out the principles governing the design of 'optimal incentive contracts' (Table 1)[6,7] including 'informativeness', that is, performance measures that allow more accurate estimates of agent effort (distinct from the influence of factors outside the agent's control); 'incentive intensity', where the strength of incentives reflects the likely

returns; 'monitoring intensity', where monitoring is proportionate to variation in performance; and 'equal compensation', intended to avoid perverse consequences where providing strong incentives for some activities reduces efforts elsewhere.

As commissioning organisations in the English NHS, PCTs can draw on a range of incentives and contractual flexibilities to encourage service providers to improve quality, increase choice, meet performance targets, encourage 'care closer to home', and respond to local health needs. In relation to primary care, commissioners can reward practices for managing demand for acute care,[8] set targets which extend the nationally agreed P4P Quality and Outcomes Framework (QOF), [9] create separate innovation funds or reward schemes, and deploy a range of enhanced services, agreed as part of the national 2004 General Medical Services (GMS) contract.[10] The package of enhanced services (Directed, National and Local) is additional to essential services provided to all patients through the GMS contract, and is non-mandatory for general practices. Directed Enhanced Services (DESs) must be offered to all eligible practices by PCTs; National Enhanced Services (NESs) are designed to meet local needs but follow national specifications and benchmark pricing; Local Enhanced Services (LESs) are developed locally with PCTs choosing which services to commission and agreeing incentives to be offered. LESs may also be used to incentivise enhanced performance in relation to the QOF, essential services, DESs, or to encourage early adoption of planned DESs.

Recent reviews of incentives in general practice have largely focused on the impact of the QOF[3, 11] and there have been no empirical evaluations of LESs. However, expenditure on LESs has increased substantially over recent years - rising from almost £251 million in 2007/08 to a projected £372 million in 2009/10 - equivalent to a 48% increase over two years.[12] This article analyses qualitative and quantitative data on commissioners' use of LESs

to incentivise preventive services in primary care, highlighting benefits and disadvantages and the relative importance of financial and other sources of motivation. It forms part of a wider study on the impact of governance structures and incentive arrangements on commissioning for health and well-being.[13]

Methods

The study drew on three sources of data: interviews from 10 case study sites; LES documentation from these sites; and a national questionnaire survey of PCTs. Sampling with replacement occurred until 10 PCTs meeting selection criteria were recruited, out of a total of 22 PCTs invited. Case study sites reflected: levels of deprivation (with half the sample falling within the 10% most deprived areas in England); a regional spread; and a range of population size and performance ratings. Interviewees were selected to reflect key decision-making roles in commissioning: PCT Chief Executives (3), Directors, including Directors of Public Health (DsPH) (44) and Non-Executive Directors (7) as well as General Practitioners (GPs) acting as Professional Executive Committee (PEC) chairs (8) and practice-based commissioning (PBC) leads (12). Interview schedules were piloted and one hour semi-structured interviews were carried out either face-to-face (52) or by telephone (22) in two phases between October 2008 and January 2010. Written consent was obtained prior to interviews, which were recorded and transcribed. This article focuses on responses to questions on: incentives for providing additional preventive services in primary care; the most effective ways of incentivising preventive services; and the relative importance of financial and other sources of motivation. Themes arising from interview data were identified inductively, grouped by two members of the project team (LM, SC) and analysed by frequency, site and category of respondent.

Using Freedom of Information (FOI) requests or local contacts, LESs from the ten case study sites were collected in 2009. Informed by findings from first phase fieldwork, a national survey of PCTs was undertaken between October and December 2009. It was distributed through the web tool SurveyMonkey to 508 individuals in 146/152 PCTs: PCT Board Chairs; DsPH; PEC Chair/ Medical Directors; and Directors of Commissioning (some PCTs share Boards, hence reduced numbers). The survey explored how PCTs prioritised, incentivised and commissioned health and well-being services Analysis of interview data was informed by a review of economic perspectives on incentives carried out as part of the project and compared with the documentary analysis of LESs and relevant results from the national on-line survey.

Results

Responses to the national survey were received from 65% (95/146) of PCTs with representation from all regions, most major cities and rural areas: the individual response rate was 27% (138/508). LESs were the most commonly cited vehicle for incentivising preventive activities in primary care, used by 70 % of responding PCTs (Figure 1).

Documentary and interview analysis identified 155 LESs across the 10 case study sites. Of these, 72 related to preventive services (Table 2) and 61 related to providing care closer to home (where additional to National and Directed Enhanced Services) in areas such as near patient testing and monitoring, diagnostics and screening, minor surgery, and management of conditions including heart failure, diabetes and deep vein thrombosis. The remainder related

to improving access, ethnicity monitoring, practice-based commissioning, training support, data collection and information technology.

Table 2 shows that 7/10 sites had smoking cessation LESs with practices and /or community pharmacies; five had LESs in place for cardiovascular (CVD) risk assessment and management and seven had LESs for Chlamydia screening. Other preventive LESs included: additional or more frequent patient data to that required for the QOF; falls prevention; proactive care of elderly people; and enhanced services for depression and anxiety. Payment was either activity-related (for example, vaccinations, minor surgery or contraceptive implants) or based on the number of registered patients (for example, CVD risk management). In some cases, payment was contingent on achieving targets or on the provision of additional information (such as baseline assessments and audits). For example, in one site, the LES payment was withheld if more than 10% of patients with diabetes attended secondary care. On the other hand, some LESs included bonus payments for reaching certain targets. For example, in one CVD LES, a bonus payment of £100 per 1000 patients on the practice list was applied if the practice screened 10% of the practice target population.

In the national survey, respondents were asked whether they considered LESs an effective route for commissioning health and well-being services. Of the 72 respondents who answered this survey question 8% rated LESs as ‘very effective’, 65% ‘quite effective’, 23% ‘not very effective’ and 3% ‘very ineffective’.

LESs were discussed in 58/74 interviews (Table 3). Most interviewees (62%) considered them an effective and appropriate route for incentivising GPs, given the ‘small business’ and

entrepreneurial model of primary care, inflexibility of the core GMS contract, and the increased workload involved. Interviewees noted the effectiveness of LESs in pump-priming change; addressing gaps in the QOF; helping to meet PCT targets for smoking cessation and Chlamydia screening; addressing inequalities through management of CVD; and encouraging GPs to focus on health and well-being and care closer to home. For example, smoking cessation targets in one site had been exceeded by increasing incentives for practices and some PCTs had chosen to weight LES payments to encourage targeting of specific populations or areas.

In two sites with low numbers of LESs, there were plans to extend their use. In contrast, interviewees from three sites with the highest numbers of LESs commented on their incremental and piecemeal development, which could lead to 'cherry picking' as well as confusion amongst providers:

'And actually… it's really difficult to keep a handle on all those different ones and try to remember, well does this person fit the criteria for a depression one… and you're trying to do this in your consultations.' (PEC Chair)

Their complexity had resulted in initiatives to rationalise LESs through combining related or commonly adopted LESs or channelling agreements through networks of GPs rather than through individual practices to encourage standardisation of care, improve performance management and develop collaboration. Common factors were also being explored. For example, a LES for motivational interviewing could apply across a range of risk factors.

Despite their success in motivating GPs, 43% of interviewees identified one or more drawbacks to LESs. Most commonly cited was their voluntary nature resulting in an uneven and inequitable distribution of services if practices refused to take them up, did not need the additional resources or if services were not targeted. Even if targets for payment for the LESs were met, this did not guarantee that the most vulnerable or those at highest risk had been reached. Moreover, disparity in the quality of general practice, as indicated, for example, in QOF scores, could be reflected in implementation.

Second were weaknesses in specification, monitoring and evaluation, described by one interviewee as follows:

'Well ... I think that there's a complexity around the enhanced services. We've got over 30 and sometimes I think the practices themselves lose sight of what it is they're trying to do. Secondly, I think some of the specifications are very weak and not particularly helpful. And thirdly the data reporting against them isn't perfect at all. So there's probably some way to go in terms of a leverage or a tool.' (Director of Commissioning)

LESs also reflected wider problems with using incentives. At a contractual level it was important to get the level of incentives right and understand 'the science of incentives'. A Director of Finance commented:

'We don't yet fully understand and haven't got a grasp on what we can do to maximise the potential of contracts that we are having to put in place and how incentives and disincentives can influence things.'

LESs were considered a short-term solution. Interviewees noted the importance of other sources of motivation, including benchmarking, audit, peer review and peer approval; professional and public sector ethos; concern for patients and health of the local population; and effective levels of engagement with commissioners. It was argued that long-term cultural change was required if GPs were to provide proactive preventive care and this needed better understanding of a range of motivating factors.

There were also perverse consequences of adopting a transactional and micro-management approach, as reflected in both the LES and the QOF. Incentives initially offered to pump-prime change in the short-term could become perceived as a permanent financial resource by providers requiring 'a LES for everything'; conversely there was a risk of rewarding services which were already being provided or which should be considered part of a core professional role. Financial incentives could serve to undermine intrinsic motivation (the 'crowding out' problem). One interviewee commented:

'I mean as a doctor myself, I do question do you need to incentivise a professional to do their job they're being paid for, and sometimes I think we overrate the incentive bit and forget about the compelling information, the message, the audit and the feedback to professionals to show the impact of engaging in health and well-being.' (Director of Strategic Planning)

Interviewees in four sites highlighted a lack of alignment of incentives across the healthcare system or the failure to consider the impact of incentives on other parts of the system. One interviewee cited a lack of capacity to respond to referrals generated through a LES designed to prevent falls:

'If you put an incentive in one part of the system how's the rest of the system aligned to that? Because you can do all the proactive work in the world but if the rest of the system has still only got the capacity to respond to reactive (work) … it doesn't take long for the system to get clogged'. (PCT Director)

Incentives for preventive services highlighted the fact that prevention was not adequately prioritised within the healthcare system. One or more criticisms were raised by 28% of interviewees over the lack of incentives for health and well-being, described, for example, as an 'add on' which had to be paid for separately. Payment by Results incentivised hospital activity and there were gaps in the QOF, which concentrated on the easily measurable and allowed exception reporting. NESs did not include preventive services and there were few incentives for GPs to focus on prevention, either financially or in terms of patient approval. Health and well-being was a long-term agenda while incentives were often short-term. Proposed solutions included: incorporating a preventive component in all services; reworking payment structures and contracts to incentivise improved outcomes of care; making GPs accountable for budgets; or commissioning services from alternative providers. The dangers of funding evidence-based preventive services through optional incentive schemes rather than through core contracts were also stressed.

In six sites, interviewees observed that LESs were easy to cut in times of financial stringency, such as the current economic downturn. This raised concerns over the future of preventive services in primary care.

Discussion

Main findings of this study

LESs are the most common route for incentivising preventive services in general practice, appropriate for a 'small business' model of primary care and considered effective in pump-priming change and meeting targets. However, LESs have developed in a piecemeal manner since their introduction in 2004. They varied in level of specification, quality of monitoring and associated penalties or rewards. As an optional element of the GMS contract, they increased inequity of access to preventive services through differential take up and targeting by independent contractors, tended to be poorly implemented in low-performing practices and were seen by commissioners as an easy target for cuts. Although originally intended to address local health needs, in practice they also indicated gaps in the national P4P system for primary care (QOF) and variation in providing preventive services. The study demonstrated limitations of individual financial incentives in promoting longer-term change and the importance of also considering professional ethos, collaborative approaches and outcomes-based contracts.

What is already known on this topic

It has been demonstrated that incentives are effective in changing primary care practice [2,3,14] and that the QOF is encouraging a more systematised approach to managing long-term conditions in primary care.[11] Moreover, theoretical analyses have set out principles of optimal incentive contracts as a guide to contract specification and monitoring.[6,7] However, health and well-being are not adequately incentivised in a healthcare system where payment is largely activity-based and the emphasis is on short-term delivery.[15] The impact of specific financial incentives is influenced by the configuration and degree of alignment of incentives across a health care system[3] and financial incentives should not be considered in isolation from other sources of motivation.[5]

What this study adds

While LESs provide a means for exploring the effectiveness of financial incentives in motivating contractors to provide preventive services, neither the extent of deployment of optional short-term incentives for this purpose by commissioners nor views of their potential benefits or disadvantages have been previously analysed. This study carried out a national survey to identify LESs for preventive services and interviews with key stakeholders to identify their views.

Limitations of the study

LESs for case study sites were identified either through contacts or through FOI requests. However this is a snapshot as LESs can be established or withdrawn at short notice and are often reviewed annually. Survey questions on the value of incentives were those least frequently answered by respondents and 50% did not respond to this question. While half the case study sites were selected to reflect areas of greater deprivation, the survey was national and this limits comparison. Twenty one per cent of interviewees did not discuss LESs in any detail so did not contribute to the analysis.

Conclusion

Health and well-being services may be commissioned from a range of providers including the voluntary and community sector, independent contractors and local authorities. In England, public health commissioning is about to become more complex following the publication of the NHS White Paper[16] with a new national body, Public Health England, responsible for commissioning services through local authorities, GP consortia via a National Commissioning Board as well as for some directly provided services.[17] There is also a

greater emphasis on health outcomes, encouraging partnerships, and a local 'health premium' for local government to incentivise progress in improving health.[18]

LESs for evidence-based interventions, such as identifying CVD risk, are indicative of gaps in the QOF and of local variation in the quality of primary care. They raise questions over the expected contribution of GPs to reducing preventable morbidity, especially in the context of a more diverse provider landscape. Many of the activities currently funded through LESs, such as health check programmes, smoking cessation, prevention and treatment of alcohol misuse, falls prevention, and mental health promotion will now be commissioned through the public health budget of local authorities, which is to be ring-fenced.

Whether these changes in the commissioning architecture address current fragmentation and variability in evidence-based preventive services remains to be seen. Experience from LESs suggests that while financial incentives are effective in changing practice, outcomes-based contracts rather than activity-related incentives could encourage a more proactive approach. However, much depends on the size of the public health budget and whether preventive services continue to be viewed as an easy target for cuts in a financial downturn.

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Ethics approval

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Conflict of interest

None declared

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Figure 1: Types of Local Enhanced Services commissioned by PCTs

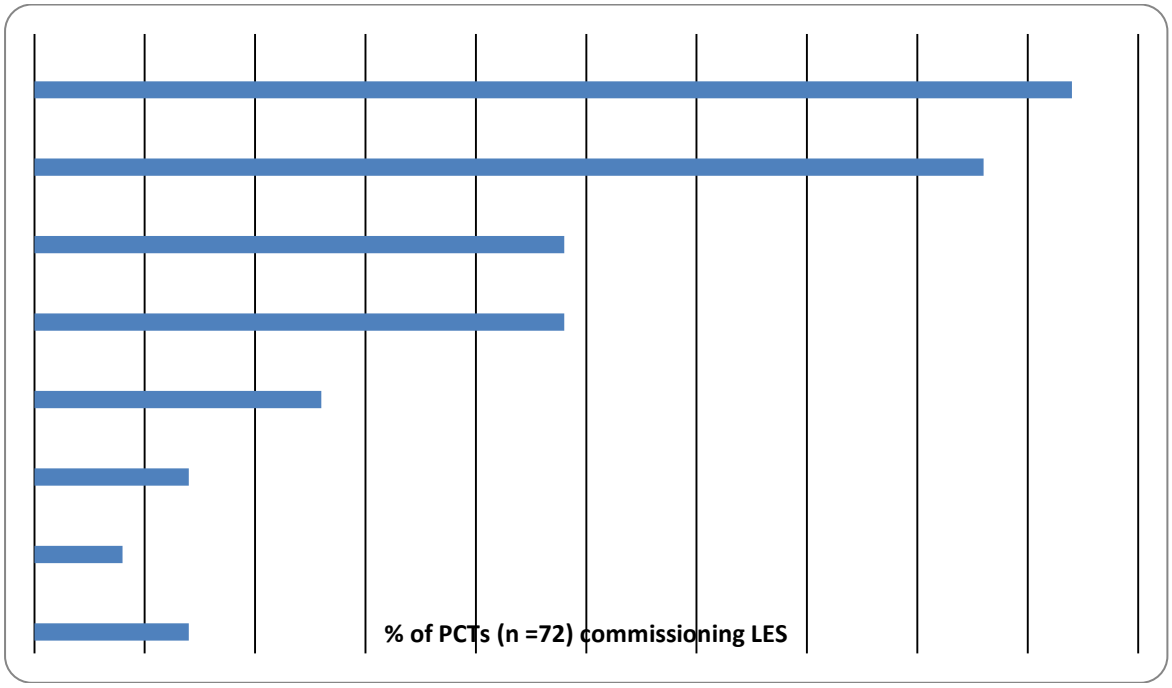

Table I: Economic principles for optimal incentive contracts [1,2]

Principle	*Definition*	*Implications for commissio*ners
The informativeness principle	Factor in performance measures that allow agent effort to be estimated more precisely and exclude performance measures that chiefly reflect factors outside of the agent's control.	Commissioners may require agents to report activity data, e.g. on efforts to follow up and support non-attenders at weight loss clinics; routine feedback on smoking status of those offered advice to quit.
The incentive-intensity principle	The strength of incentives should reflect the marginal returns to task, the accuracy with which performance is measured, the responsiveness of the agent's efforts to incentives, and the agent's risk tolerance.	Sometimes, the most difficult to reach populations are those with greatest capacity to benefit. Additional payments could be made for reaching these populations with public health interventions.
The monitoring intensity principle	Monitoring is a costly activity. More resources should be spent monitoring when it is desirable to give strong incentives, e.g. there is substantial variation in performance or performance is uniformly poor.	If benchmarking data suggest that a PCT is performing significantly below national average standards in some area (e.g. smoking cessation rates), commissioners may wish to monitor provider performance more intensively to signal the importance of changing behaviour.
The equal compensation principle	If principals cannot monitor an agent's allocation of time, incentives should ensure that the marginal returns earned by the agent are equal for all tasks the agent undertakes. Providing strong incentives for only some activities can cause agents to reduce effort in other activities.	If local public health indicators are added to the QOF, care should be taken to ensure that targets are broadly aligned with commissioner objectives; if equity issues are a concern, payments could be adjusted to reflect this (e.g. thresholds for triggering maximum payments could be raised if unmet need is concentrated in lower socioeconomic groups).

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Table 2: Distribution of Local Enhanced Services (2009) for preventive services across 10 case study sites

	Case study site										
Local Enhanced Service	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Vaccination											
HPV catch up		x	x	x	x					x	**5**
MMR catch up	x(2)			x				x			**4**
Hep B					x	x					**2**
Hep A	x										**1**
Men C (freshers)			x								**1**
Influenza (at risk groups additional to the DES)								x	x		**2**
BCG					x						**1**
Vaccine (other)											
Sexual health											
Sexual health LES					x						**1**
Chlamydia screening (GP)	x	x	x	x	x				x	x	**7**
Chlamydia screening (pharmacy)							x				**1**
Contraceptive implants		x	x			x	x	x		x	**6**
IUCD	x		x				x	x			**4**
Emergency contraception (pharmacy)	x						x				**2**
Lifestyle interventions											
Smoking cessation (GP)	x		x	x		x		x		x	**6**
Smoking cessation (Pharmacy)	x					x	x				**3**
Alcohol: case finding/ brief interventions		x	x		x				x		**4**
Drug and alcohol abuse					x						**1**
Disease prevention/early diagnosis											
CVD/CHD risk management		x		x	x	x			x		**5**
COPD					x	x					**2**
Osteoporosis diagnosis and prevention		x									**1**
Anxiety and depression					x						**1**
Vulnerable groups											
Learning disability health check		x			x			x			**3**
Substance misuse						x	x				**2**
Vulnerable older people					x						**1**
Support to carers				x						x	**2**
Falls prevention										x	**1**
Medicine non compliance (mental health) (pharmacy)							x				**1**
Improving data collection											
Public health related data (targets on smoking, obesity, breast feeding and diabetes)	x					x					**2**
Total	**9**	**7**	**7**	**6**	**12**	**8**	**7**	**6**	**4**	**6**	**72**

Table 3 Views of Local Enhanced Services: themes and sub-themes arising from the qualitative analysis

Themes							
		Sub-themes					**Sites**
1.Financial incentives are effective (62% per cent of interviewees[1])		Financial incentives motivate GPs (61% of interviewees[2])	Help meet PCT targets (16.6 %)	May reflect reward for increased workload (16.6%)	An effective route for addressing gaps in QOF (16.6%)	LESs are the only contractual option (11.6%)	10
2.LES-specific problems (43 %)		Unequal take up by practices /increase inequalities (56%)	Complex, inadequate specification / monitoring (28 %)	LESs encourage transactional approaches (16%)	Poorly implemented in low-performing practices (12%)		10
3. Other sources of motivation are important (40 %)		Concern with patient and population health (43%)	Peer approval (22%)	Cultural shifts (17 %)	Audit and feedback (9%)		9
4. Problems with financial incentives (38%)		Incentivising one part of the system leads to fragmentation/lack of alignment of incentives (27 %)	Financial incentives have only short-term impact (18%)	Tend to reward activity not outcomes (18 %)	Incentivising activities which are core to a professional role (18%)	Use of incentives is poorly understood (13.6 %)	10
5.New approaches needed (31%)		Alternative providers (45%)	Outcomes - based contracts/QOF (30%)	Make GPs accountable for budgets (20%)			9
6. Health and well-being are not adequately incentivised (28%)		QOF does not incentivise health and well being (88 %)	Payment by results does not incentivise prevention (19%)	Contracts are not outcomes - based (19%)			8

1. Total number of interviewees = 58
2. Total refers to interviewees expressing relevant main theme